	,			F_ // /	Ø 005
CENTE	TMENT OF HEALTI RS FOR MEDICARI TOP DEFICIENCIES	H AND HUMAN SERVICES E & MEDICAID SERVICES	·	REMID	PRINTED: 05/0 FORM APPR OMB NO. 0938
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(XI) DATE SURVEY COMPLETED
		09G159	B. WING		
NAME OF F	ROVIDER OR SUPPLIER	-	STRE	EET ADDRESS, CITY, STATE, ZIP CO	04/13/200
CARECO	0 02		66	ASHINGTON, DC 20012	DDE
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	10	PROVIDER'S PLAN OF CO	BBCATION
TAG	REGULATURY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I CHOULD DE LA
W 000	INITIAL COMMEN	TS	W 000		
	initiated utilizing the Seven females with reside in the facility derived from a rand	vey was conducted from April pril 13, 2007. This survey was fundamental survey process. It various degrees of disabilities. The survey sample was lom sampling of four of the			
	observations in the programs, interview member/guardians, the findings were ba	survey findings were based on group home and three day is with clients, family staff and consultants. Also, ased on review of records to dents and investigation			
in the second se	state regulatory age internal investigative. The investigation debeen abused by Direct 18, 2007. The investhat Direct Care Staff 2007. Staff #1 speak of 2007. Based on the acility's management of the investigation of the acility's management acility's management of the investigation of the mediately upon not mediately upon no mediately upon no internal investigation.				
1	 Implement disciple 	ative report recommended to be taken by the facility: inary action on the staff mination for abuse to the			
l w	rupessing the incide	inary action on the staff nt of suspension and			
MATURE D	PYCCIONS ON PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNAT		TITLE	(X6) DATE
- (///	tatement ending with an	7 /	K Ja	UP	5/10/07

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VDTB11

Facility ID: 09G169

If continuation sheet Page 1 of 16

AND PLAN	ERS FOR MEDICARE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIE A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SO COMPLE	
		09G159	B. WING			
NAME OF	PROVIDER OR SUPPLIER O 02		66	EET ADDRESS, CITY, STATE, ZIP CODE 113 6TH STREET, NW ASHINGTON, DC 20012	104/1:	3/2007
(X4) ID PREFIX TAG	CACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	LUBBE	(XS) COMPLETION DATE
W 000	mandatory training; 3. Immediate mand for all residential/nu 4. Staff to be retrain Support Plan in the 5. Staff to be retrain #1 (weekday/weeke 6. Staff to be retrain include the important documentation as rethis is not done in th 7. QMRP to further behavioral issues wi	datory incident report training raing staff; ned on Client #1's Behavior next 30 days; ned on how to support Client and) in the next 30 days; ned on how to document, to nee of daily/time eview of records show that e next 30 days; address Client #1's the next incident with the	W 000			
W 124	The surveyor determ addressed these rec implemented a syste not subjected to furth 483.420(a)(2) PROT RIGHTS The facility must ensitherefore the facility parent (if the client is of the client's medical and behavioral statu	uined that the facility had commendation and the consure that clients were ner abuse. ECTION OF CLIENTS ure the rights of all clients, must inform each client, a minor), or legal guardian, a condition, developmental	W 124			

If continuation sheet Page 2 of 16

Facility 10: 09G159

DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES			PRINTE	D: 05/01/2007
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	MULTIPLE CONSTRUCTION	(X3) DATE :	
		09G159	B. Wil	NG	_ [
NAME OF F	ROVIDER OR SUPPLIER			OTDERT ADDRESS OF A STATE OF	04/	13/2007
CAREC	02			STREET ADDRESS, CITY, STATE, ZIF 6613 6TH STREET, NW WASHINGTON, DC 20012	CODE	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 124	Continued From pa	ge 2	W ·	124		 -
	Based on record re ensure the rights of guardian to be infor condition, developm attendant risks of the			-		
	Professional (QMRI Rights Committee M April 11, 2007 at 3:5 received Risperdal 3 months and was distine HRC minutes resedation (Valium 20 appointment. Althouthe family (mother/n client's care, there we facility attempted to consent for medications and level of medical treatment. Although the HRC at and sedation, there wisks and benefits of sedation had been either mother. No systems	ualified Mental Retardation P) and review of the Human Minutes (HRC) conducted on FPM, revealed that Client #3 mg for a trial of three continued. Further review of vealed that Client #3 received mg) prior to a GYN ugh the QMRP indicated that eice) had been involved in the vas no evidence that the contact the family to obtain ions and/or sedation. gloal assessment dated July nat Client #3 functions at the ental retardation and was indent decisions regarding pproved the trial medications was no evidence that the the potential side effects of xplained to the client, and/or em had been established to o for consent or legally		W124 Although attempts contact the sister of was determined (by response to corresp phone calls) that the chooses not to be in care at this time. To QMRP will continut toward the successful appointment of a guilegally sanctioned a (Note: Client #3's note deceased)	f client #3, it values and e family avolved in her herefore, the efforts ardian for advocacy.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VDTB11

Facility ID: 09G159

If continuation sheet Page 3 of 16

DEPAI	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTEI	D: 05/0 1/2007
CENTI	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM	APPROVED
ISIALEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI	ULTIPLE CONSTRUCTION LDING	(X3) DATE (
	·	09G159	B. WIN	G		•
NAME OF	PROVIDER OR SUPPLIER		- -	ATDY	04/	13/2007
CAREC	O 02			STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE	MILL D. DE	(X5) COMPLETION DATE
W 130	483,420(a)(7) PROTRIGHTS	TECTION OF CLIENTS	W 1	30		
	The facility must en Therefore, the facilit treatment and care	sure the rights of all clients. ty must ensure privacy during of personal needs.				
W 153	implement an effect clients' rights for privacy clients #1 and #7) The findings include The facility failed to a privacy during care of #1 and #7 as eviden. 1. During evening of beginning at 3:03 PN exposed each time a dining table. At no time and the province of the privacy during table are of the privacy during care of #1 and #7 as eviden. 2. Observations con approximately 6:03 Pout of her bedroom where the privacy of the privacy o	ensure the clients rights to of personal needs for Client ced by the following: bbservations on April 10, 2007 f. Client #3 buttock was the got up from the sofa and me did the direct care staff of Client #3 to pull down her from the sofa. ducted on April 10, 2007 at the revealed Client #7 coming with her shirt up, exposing her poserved pulling up her pants, served this privacy issue, at the staff observed to redirect ting dressed in her room	W 15		at staff raining now to ivacy; ving and a reduce self.	
				1	ľ	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTED:	05/01/2007
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	FORM . OMB NO	APPROVED 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) N A. BU		TIPLE CONSTRUCTION NG	(X3) DATE SL COMPLE	RVEY
	<u></u>	09G159	B. Wil	NG_		04/4	
NAMEOF	PROVIDER OR SUPPLIER			Tar	PORT ARREST CITY OFFICE	04/13	3/2007
CARECO	0 02			'	REET ADDRESS, CITY. STATE. ZIP CODE 6613 6TH STREET, NW		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	·	ь_	WASHINGTON, DC 20012		
PRÉFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ŦΧ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS:REFERENCED TO THE APPRINCE DEFICIENCY)	UDRE	(XS) COMPLETION DATE
W 153	Continued From page	ge 4 .	W	153		·	
	The facility must en mistreatment, negle injuries of unknown immediately to the a	sure that all allegations of ect or abuse, as well as source, are reported administrator or to other ce with State law through	**	100			
W 159	Based on interview, and incident reports incident Manageme failed to ensure that mistreatment, negle of unknown origin with administrator or by State Law [22DC through established clients residing in the #7) The findings include The facility failed to written and reported administrator as evidence as Review of the face PM, revealed an investigation of report revealed that another staff person threatening to withing reasons and talking The report also reverse.	ct or abuse as well as injuries ere reported immediately to to other officials as required MR Chapter 35 - 3519.10] procedures for three of seven e facility. (Clients #1, #5, and ensure that all incidents were immediately to the denced below: elitity's IMS on 4/11/07 at 1:00 estigative report pertaining an abuse. The investigative on 2/20/07, staff witnessed being abusive to Client #1 by old food from her for various in harsh tones to the client. alled that the actual incident but was not reported to the (2) days.	W 1			nire vill ble,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VDTB11

Facility ID: 09G159

If continuation sheet Page 5 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/01/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 09G159 04/13/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 02 6613 6TH STREET, NW WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY W 159 Continued From page 5 W 159 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP), failed to adequately W159 monitor, integrate and coordinate each client's This STANDARD will be met as active treatment. follows: 1. Cross ref. W130 The findings include: 2. Cross ref. W153 1. The QMRP failed to ensure that an effective Cross ref. W193 system was implemented to protect the clients' rights for privacy during personal care needs. [See W130] 2. The QMRP failed to ensure that all injuries of unknown origin were reported and/or in accordance with the facility's policy and procedures. [See W153] The QMRP failed to ensure that staff implemented Client #3's Behavioral Support Plan (BSP). [See W193] 483.430(e)(3) STAFF TRAINING PROGRAM W 193 W 193 Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility staff failed to demonstrate competency in implementation of Clients #2 and

FORM CM5-2567(02-99) Previous Versions Obsolete

Event ID: VDT811

Facility ID: 09G159

If continuation sheet Page 6 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/01/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G159 NAME OF PROVIDER OR SUPPLIER 04/13/2007 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 02 6613 6TH STREET, NW WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX ľD PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE TAG PREFIX TAG DATE DEFICIENCY W 193 Continued From page 6 W 193 #3's Behavior Support Plan (BSP). The findings include: 1. On April 10, 2007 at approximately 6:15 PM, Client #2 was observed going on a community walk along with her peers and staff, including the W193 client's one to one staff. Approximately 30 This STANDARD will be met as minutes later, a staff telephoned the facility to follows: report that Client #2 was agitated and may exhibit behaviors when returning to the facility. When Staff were trained on the client returned to the facility, the client's one to implementation of the BSP's for one was interviewed about the client's behavior all residents on March 9, 2007. on the outing. The staff reported that the client A second session was scheduled walked out of the store when she could not have a bigger bag of potato chips. The staff for those who missed the first acknowledged that the client had target behaviors offering. In addition, all staff are that had not been observed since she had been trained on behavior management assigned as the one to one in February 2007. prior to or upon deployment into The staff was asked if she was aware of the Client's behavioral strategies and interventions the home. Additional measures and was knowledgeable as to their will be taken as follows: implementation. The staff stated that she had not 1. All staff have been rebeen trained on the client's BSP. trained on On April 12, 2007, at approximately 12:00 PM, implementation of all Client #2's BSP dated April 6, 2007 was reviewed. BSP's including the one The BSP revealed the following target behaviors: developed for client #2. 1) Noncompliance to medical appointment; 2) Noncompliance to general staff directives Staff will not be assigned (refusing to attend day program, refusing to to support clients until participate in assigned tasks, and overall refusals they have a fundamental to follow staff directives); 3) Verbal aggression understanding of the BSP. (cursing/using profanity at others, making insulting comments, and responding to This acknowledgement hallucinations); 4) Stomping upstairs and will be documented. slamming her bedroom door, 5) Property Destruction (throwing/breaking objects); 6) Verbal threats (threatening to engage in physical

FORM CMS-2567(02-99) Previous Versions Obsolete

Event (D: VDTB11

Facility ID; 09G159

If continuation sheet Page 7 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/01/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G159 04/13/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 02 6613 6TH STREET, NW WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 193 Continued From page 7 W 193 aggression towards others, and threatening to call the police or her sister); 7) Self-Injurious head banging (hitting head against the wall); 8) Auditory hallucination; and 9) Running into street. Interview with the Qualified Mental Retardation Professional (QMRP) on April 13, 2007 at approximately 1:30 PM confirmed that the staff had not received training on Client #2's BSP and stated that training on the BSP was scheduled for April 14, 2007. It should be noted that the one to one staff has been providing direct supervision since February 15, 2007. On April 10, 2007, between 3:03 PM - 3:51 PM, Client #3 was observed rubbing her hair and 2. Staff will receive head repeatedly. During this time frame, staff additional training on and other clients were involved in preparing implementing the active dinner and participating in housekeeping treatment routine for activities. Client #3 was allowed to sit idle without client #3 to properly any constructive activities or staff interaction. support her in managing Review of the BSP, dated January 28, 2007, behavior. revealed that the client had targeted behaviors of 3. The staffing pattern will "Trichotillomanic and Repetitive Face Rubbing". Further review of the BSP reflected that be reviewed with the statement "Do not allow the client to be idle for governing body to long periods of time to avoid target behaviors." determine how best to There was no evidence that staff implemented support client #3 Client #3's BSP proactive strategies as prescribed in the plan. 5/3.1/07 483.440(d)(1) PROGRAM IMPLEMENTATION W 249 W 249 As soon as the interdisciplinary team has formulated a client's individual program plan. each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the

FORM CMS-2567(02-98) Previous Versions Obsolate

Event ID: VD7B11

Facility ID; 09G159

If continuation sheet Page 8 of 16

ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE :	
		09G159	B. WING			4-2-
CAREC	PROVIDER OR SUPPLIER		s	TREET ADDRÉSS, CITY. STATE, ZIP COD 6613 6TH STREET, NW WASHINGTON, DC 20012		<u>13/2007</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORF (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	HOLED BE	(XS) COMPLET
W 249	Continued From pa objectives identified plan.	ge 8 I in the individual program	W 24			
	review, the facility's competency in imple Support Plan (BSP) The finding includes On April 10, 2007, b Client #3 was obserrepeatedly. During a other clients were in and participating ho #3 was allowed to si	netween 3:03 PM - 3:51 PM ved rubbing her hair and head this time frame, staff and volved in preparing dinner use keeping activities. Client it idle without any constructive	-	W249 Cross reference response t W193 #2 & #3	for	
W 263	Review of the BSP, revealed that the clie "Trichotillomanic and Further review of the statement "Do not allong periods of time There was no evider Client #3's BSP prosprescribed in the pia 483.440(f)(3)(ii) PROCHANGE The committee shoulars conducted prily was no evider than the pia 483.440(f)(3)(ii) PROCHANGE	dated January 28, 2007, ent had targeted behaviors of discretifive Face Rubbing". e BSP reflected that at low the client to be idle for to avoid target behaviors." nee that staff implemented active strategies as n. DGRAM MONITORING &	W 26 3			
- 1	consent of the client, minor) or legal guard	Darents (if the client is a				

Event ID: VDT811

Facility ID: 09G159

If continuation sheet Page 9 of 16

ICALEMEN	II ()E DEELC)ENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(V2) M(1)	TIDLE OCUPATION	OMB NO	4 APPROV 2. 0938- 03
MO FEMI	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILD	TIPLE CONSTRUCTION	(X3) DATE : COMPL	SURVEY ETED
		09G159	B. WING			
NAME OF	PROVIDER OR SUPPLIER				04/	13/2007
CAREC	0 02		- 1	TREET ADDRESS, CITY, STATE, ZIP CO 8613 6TH STREET, NW WASHINGTON, DC 20012	DE .	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID			
TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)		(X5) COMPLET DATE
W 263	Continued From pa	ge 9	14/ 10:			-
	This STANDARD is Based on observation review the facility facility facility facility facility facility facility facility facility facility.	s not met as evidenced by: on, interview, and record illed to provide written or the use of psychotropic dation for one of two clients	W 26:			
	The finding include:			Word		
	for the use of Client medications. Behavi	rights committee failed to d consent had been obtained #1's psychotropic for Support Plan, and sedative medical appointments. [See	·	W263 Cross reference response W124	for	
N 322	483.460(a)(3) PHYS	CICIAN SERVICES	W 322			
	The facility must pro- general medical care	vide or obtain preventive and				
	facility failed to provid	not met as evidenced by; iew, and record review the de follow-up preventive care ints residing in the facility.				
1	The finding includes:					
6 6 7	evealed an investiga i/12/06. The investiga i/6/06 Client #7 arrive irogram and reported the Residential Direct ard area on the clien	al incident report log book 7 at approximately 1:00 PM itlon/incident report dated pation report revealed that on ed home from the day 1 that her breast was hurting, ctor observed a red swollen it's breast in the same us bump thought to be a		·		

Event ID: VDTB11

Facility ID: 09G159

If continuation sheet Page 10 of 16

PIRIEME	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	(X3) DATE S	APPROV 0. 0938-0 SURVEY
		09G159	A. BUII B. WIN		COMPLETED	
NAME OF	PROVIDER OR SUPPLIER		-1 i		04/1	13/2007
CAREC	O 02			STREET ADDRESS, CITY. STATE, ZIP CODE GG13 GTH STREET, NW WASHINGTON, DO COOLS		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u>ID</u>	WASHINGTON, DC 20012		
PREFIX TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFU TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	Out ore	(X5 CDMPLE DAT
W 322	Continued From pe	ige 10	W 3			 _
-	mosquito bite. The observed the area	e facility's charge nurse and agreed that the client to the emergency room.	VV 3	W322 The referenced incident h		
	Review of the "Gen Discharge Instruction that Client #7 was of	ne "General Emergency Department nstructions, dated 6/6/07, revealed f7 was diagnosed with absence Broad		investigated at the time of occurrence. It was determ that the discharge instruct	ined ions	
	discharge instruction	inges c/w Breast tumor. The ns also revealed that the client ith a physician in 2-3 days		Additionally, the investigation of the control of t	ation arge	
	The nurse stated the	PM the facility's nurse was e status of the follow-up visit at the emergency room as were not included in the		instructions were contradi within itself and did not in what timeframe the client be seen ("follow up in 2-3	idicated was to	
	was not seen by a phospital. On June 1 initial emergency roo	rt; and therefore, the client ohysician as ordered by the 2, 2006, 6 days after the orn visit, the client was taken again due to continued pain		[blank] without fail without Recommendations from the investigation included have nurse review ER discharge	nat ing the	
V 331	the client was admit debridement of the t	g this emergency room visit, led to the hospital for surgical preast abscess		instructions with the primare physician, who would determ the next course of action,	rmine within	
- 001	483.460(c) NURSIN The facility must pro services in accordan	Vide clients with pursing	W 33	24 hours of the emergency treatment. This recommen remains in place.	dation	 -
j		-			5/10/07	İ
	review the facility fall services were provid	ed in accordance with the		·		,
l	The findings include	•				

Facility ID: 09G159

if continuation sheet Page 11 of 16

SIATEMEN	RS FOR MEDICAR IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE S	APPROV 0. 0938-03 SURVEY
		09G159	A. BUILD B. WING		COMPL	ETED
NAME OF	PROMDER OR SUPPLIER		04/13/2007		13/2007	
CAREC	0 02		ş	STREET ADDRESS, CITY, STATE, ZIP CO 6613 6TH STREET, NW WASHINGTON, DC 20012	DE	_
(X4) ID PREFIX TAG	I CEACH DEFICIENC	ATEMENT OF DÉFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	たいつしょう トニ	(X5) COMPLET DATE
W 331	The facility's nuthat current Physic	age 11 Irsing services failed to ensure iran's Orders (PO) for Client ure Plus once a day.	W 33	DEFICIENCY)		-
	was observed duning stew, biscuits, sala which were served consumed 100% or indicated that the conditional state of the salar weight since Client #3's medical 12:40 PM revealed 2007. The PO revealed 2007. The PO revealed Ensure Placeted Ensure Ensur	at approximately 5:30 Client #3 ng dinner being served beef d, peaches, water, and juice family style. The client f the meal. Interview with staff lient was a good eater and had e last survey penod. Review of records on April 12, 2007 at current PO dated April 1, ealed that Client #3's diet order us one (1) can three times review of the Medication ords at approximately 1:00 PM i #3 received ensure once a rifional assessment, dated reflected a dietary continue Ensure Plus once a		W331 This STANDARD will I follows: 1. The current physician has been corrected. All physician orders will be monthly to ensure accur printing. Additionally, a will be ensured through audits by the Director of and QA Departments.	order reviewed acy in accuracy routine	
	feeding order. Accorder for Ensure Plucan three times daily 2006. The charge r	t 2:38 PM, the facility's charge red to clarify the supplemental ording to the nurse, Client #3's us was decreased from one y to one can dally in October ourse acknowledged that r for ensure plus needed to current PO.		2. Cross reference refor W322	esponse	
	revealed an investig 5/12/05. The investig 5/6/06 Client #7 arriv program and reporte	usual incident report log book 17 at approximately 1:00 PM ation/incident report dated gative report revealed that on yed home from the day at that her breast was hurting. actor observed a red swollen				

JIMIEME	:NI (): DEELCENALE:	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		·	OMB N	M APPROVE D. 0938- 039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILD	TIPLE CONSTRUCTION ING	(X3) DATE COMPI	SURVEY
		09G159	B. WING	····		•
NAME OF	PROVIDER OR SUPPLIER				04/	13/2007
CAREC	02		1	TREET ADDRESS, CITY, STATE, ZIP COD. 6613 6TH STREET, NW	E	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	,	WASHINGTON, DC 20012		
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	ガヘバル ちょうし	COMPLETIO DATE
W 331	Continued From page	ge 12	14/ 20			
	hard area on the cild location of the previ- mosquito bite. The observed the area a	ent's breast in the same ous bump thought to be a facility's charge nurse and agreed that the client of the emergency room.	W 331			
	that Client #7 was di Vinflammatory char Further review of the	eral Emergency Department ns, dated 6/6/07, revealed agnosed with abscess Breast ages c/w Breast tumor, discharge instructions ent was to "follow-up with a s without fail."				
W 338	The nurse stated that discharge instruction client's medical chart was not seen by a phospital. On June 12 initial emergency rooms in her breast. During	M the facility's nurse was status of the follow-up visit. It the emergency room is were not included in the client hysician as ordered by the client as ordered by the client was taken wisit, the client was taken this emergency room visit, and to the hospital for surgical reast abscess.	W 338	****		
	review of their health any necessary action physician to address	st include, for those clients ng a medical care plan, a status which must result in (including referral to a client health problems).				
4	pased on record revie	not met as evidenced by: w, the facility failed to follow up for one of seven				

Event ID: VDTB11

Facility ID: 09G159

If continuation sheet Page 13 of 16

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTED	: 05/01/2007
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		iultipi Lding	LE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
	·	09G159	B. WIN	IG	·	04/4	2/2007
NAME OF	PROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	3/2007
CAREC	O 02			661	3 9TH STREET, NW		
~				WA	ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	KODE	(X5) COMPLETION DATE
W 338	Continued From page	ge 13	W 3	338			
	The finding includes	<u>.</u>					! !
		i			W338		
	Record review of the	e unusual incident report log			Cross reference response to		
	PM revealed an inve	4/11/07 at approximately 1:00 astigative/incident report dated			W322		! .
	16/72/06. The invest	igative report revealed that on i					j
	6/6/06 Client #7 am	ved home from the day					! :
	The Residential Dire	ed that her breast was hurting, ector observed a red swollen					
	hard area on the clie	ent's breast in the same					!
	location of the previous	DUS bump thought to be a					
	mosquito bite. The	facility's charge nurse					
	Deeded to be sent to	nd agreed that the client the emergency room.					
		•		1			
	Review of the "Gene	eral Emergency Department					
	Discharge Instruction	ns. dated 6/6/07 revealed			•		
	V Inflammatory char	agnosed with abscess Breast ages c/w Breast tumor.					
	Further review of the	discharge instructions		- }			
	revealed that the clie	ent was to "follow-up with a				1	
	physician in 2-3 days	s without fail."					
	On 4/12/07 at 2:38 F	M the facility's nurse was		1			
	interviewed as to the	status of the follow-up visit					
·	The nurse stated that	it the emergency room					
	client's medical char	is were not included in the t; and therefore, the client					
	was not seen by a p	hysician as ordered by the		-	•		
	nospital. On June 1:	2, 2006, 6 days after the			•		
ļ	to emergency moment	om visit, the client was taken again due to continued pain			-		
j	in her breast. During	this emergency room visit					
	the client was admitt	ed to the hospital for surrical					
\N/ 440	depridement of the b	reast abscess.					
W 440	483,470(i)(1) EVACL	JATION DRILLS	W 44	40			Í
	The facility must hold	l evacuation drills at least					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VDTB11

Facility ID: 09G158

If continuation sheet Page 14 of 16

	NT OF DEFICIENCIES LOF CORRECTION	& MEDICAID SERVICES & MEDICAID SERVICES	(X2) MUL	TIPLE CONSTRUCTION	FORM APPROVE OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		09 G 159			COMP	re i po
NAME OF	PROVIDER OR SUPPLIER	090138			04/	13/2007
CAREC	O 02	-	1	REET ADDRESS, CITY, STATE, ZIP COD 6613 6TH STREET, NW	Ę	
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	UOULBEE	(X5) COMPLETIO DATE
W 440	Continued From pag	10.44		DEFICIENCY)	THOI NATE	DAIG
,	quarterly for each sh	ift of personnel.	W 440			
	facility failed to hold all shifts. The finding includes: Interview with the Qu Professional (QMRP) pattern on 4/11/07 at scheduled shifts are a Weekdays/Weekend 1st Shift 7 AM to 3 PM 2nd Shift 3 PM to 11 I 3rd Shift 11 PM to 7 F	alified Mental Retardation and review of the staffing 3:11PM revealed the as follows: M - 2 PM to 3 PM PM - 3 PM to 11 PM PM - 11 PM to 9 AM		W440 The Residential Director review the evacuation dr minimally every quarter ensure that each shift has minimum amount of pracdrills. Reviews will be documented and any pronoted in the drills will be immediately reported to to QMRP.	ills to the ctice blems	
 	hold fire evacuation di quarterly basis. Drills third shift,	were not conducted on the		-		
	183.470(l)(1) INFECTI There must be an action prevention, control, an and communicable dis	ve program for the	W 455			
fa	'4444 OII OOSEIVEIION :	ot met as evidenced by: and interview, the facility plementation of infection revent communicable				

If continuation sheet Page 15 of 16

Facility ID: 09G159

DEPAR	TMENT OF HEALTH	HAND HUMAN SERVICES			Dette see	_
<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES			PRINTE	D; 05/01/2001 MAPPROVED
1 SIVIEMED	IT OF DEPICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION	OMB NO	<u>), 0938-0391</u> survey
		1	A. BUIL		СОМР	LETED"
		09G159	B. WIN	3 <u></u>		
NAME OF I	PROVIDER OR SUPPLIER		<u>''</u>	STREET ADDRESS CITY AT IT		13/2007
CAREC				STREET ADDRESS, CITY. STATE, ZIP CO 6613 6TH STREET, NW WASHINGTON, DC 20012	DE	
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	CHOURNE	(X5) COMPLETION DATE
W 455	Continued From page	te 15	1			
	infectious diseases the sample. (Client	for one of clients included to	W 45	is		
	The finding includes	r ·		•		
ĺ	table. The Client pictable using her hand the direct care staff that Client #1 often at the process. The diffat they encourage to pick up or eat spill evidence that infectic	approximately 5:40 PM, each from her bowl onto the cked the peach up from the list and ate it. Interview with on the same day revealed eats rapidly and spills food in rect care staff also revealed the Client slow down and not led food. There was no on control procedures to ble infectious diseases were		W455 This STANDARD will follows: Staff will receive a training on infection of the Director of Nursing.	additional ontrol by	
)	

FORM CMS-2567(02-98) Previous Versions Obsolete

Event ID: VDTB11

Facility ID: 09G159

If continuation sheet Page 16 of 18

AND PLAN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RVCLIA (X2) MI 19ER: A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE . COMPI	FORM APPRO (X3) DATE SURVEY COMPLETED	
		09G159	B. WIN	G			
NAMEOF	PROVIDER OR SUPPLIER		STREET ADDRESS, CIT	Y. STATE, ZIP CODE	04/	13/2007	
CARECO 02 6613 6TH WASHING		6613 6TH STREET WASHINGTON, DO	I'H STREET, NW				
(X4) ID PREFIX TAG	I GOOD DENICIENCE	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X6) COMPLE DATE	
t t t t t t t t t t t t t t t t t t t	initiated utilizing a fixed property of the seven females with disabilities reside in sample was derived four of the seven cli were based on obse and three day programily member/guar Also, the findings we records to include uninvestigation reports NOTE: Prior to the restate regulatory ager internal investigation deliberation de	vey was conducted from pril 13, 2007. This surrender that survey provarious degrees of the facility. The survey from a random samplents. The survey findigrous in the group it ams, interviews with conditions in the group it ams, interviews with conditions, staff and consumere based on review of musual incident and recertification survey, the report on March 22, 2 termined that Client #1 or Festigative report docume f #2 who witnessed the stage on the investigation of until two days later of assed on the investigation notification. The report recomment of the taken by the facility action on the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the staff minations for abuse to the part action of the part acti	ey was ocess. ey ling of lings home lients, altants. Ithe y's 2007. I had ebruary ented e n a od; did on ative both ve ded lity: If the ded lity:	DEFICIENC	7		
	n Administration RECTOR'S OR PROVIDER	Dana S.	al.	O _D TITLE	(X	5) DATE	

ND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	BER:	IULTIPLE CONSTRUCTION LDING	(X3) DATE	APPROVI
445.00		09G159	B. Wil	NG	_	
AME OF	PROVIDER OR SUPPLIER		STREEY ADDRESS, C	TY. STATE, ZIP CODE	04/	13/2007
CAREC	0 02		6613 6TH STREE' WASHINGTON, D	r Nw		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI	ID.	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
1 000	Continued From pa	ige 1	1000	DEFICIENC	(Y)	DATE
	ior an residentia Mil			·		
	Cabboir Light III IDE		Ì			
	5. Starr to be retrain#1 (Weekday/weeke	ned on how to support and) in the next 30 days	Client			
	a.aaa me moonat	WIEW of moonds above				
	7. QMRP to further behavioral issues wi and to discuss this re Human Rights Comr	th the Interdisciplinary	tea m			
t t	 Conduct bi-weekly of allow them to disciple. 	y meetings with the res uss their concerns,	sidents	·		
İr	AAAAAAA HIRKE LEW	M to engine that all all all all all all all all all a	s were			
ĺ	504.1 HOUSEKEEP		1 090			
ar	nd sanitary manner:	ior of each GHMRP sh clean, orderly, attractiv and be free of rubbish, and objection	'e,			
fei	nis Statute is not me ased on observation iled to ensure the int of Administration	et as evidenced by: and interview, the GHI derior of the facility was	MRP			

Te

6469

VDTB11

If continuation sheet 2 of 7

STATEME AND PLAN	ENT OF DÉFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	R/CLIA MBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	09G159		B, WING		041	45/55-
			STREET ADD	DRESS, CITY.	STATE, ZIP CODE	1 04/	13/2007
CAREC	O 02		6613 6TH Washing	STREET, N	NW 20012		
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIETORY)	(II to	(X5 COMPI DAT
1 090	Continued From pa	ge 2		1 090	JENOIZRCY)		 -
		e, clean, orderly, attra	ctive and	1000			
	The finding includes	:					
	on April 13, 2007 be	erview with the Residenvironmental walk the ginning at 3:08 PM recated first floor right at a strong urine smell.	rough evealed				
1 091	3504.2 HOUSEKEE	PING		1 091			
	DA MAII COURTUICIEU	naintenance equipme properly maintained a nction for which it is to			1090 The bathrooms will be clean	ed	-:
	This Statute is not me Based on observation failed to maintain the GHMRP in a in a saft and sanitary manner.	ns and interview, the interior and exterior of a clean and exterior and exterior of a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean and a clean a clean and a clean a clean and a clean a clea			and disinfected daily. 5/10/07 1091		
-	The finding includes:				The ballisters ["arms"] of the	,	
t	Observation and inter Director during the er on April 13, 2007 beg that the stalrway lead arms detached from t	ivironmental walk thro inning at 3:08 PM rev ing to the third level b	ough		upper banister will be repaire the maintenance department to 5/31/07.	ed by prior	
1135 3	3505.5 FIRE SAFETY	•	1	135	•		
-	Each GHMRP shall co order to test the effect our (4) times a year fo	IVENOSS of the oles a	drills in t least				
.	on Administration						

If continuation sheet 3 of 7

Health	Regulation Administr	ation		•		FORM	APPROVED
SYATEM AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MULTA BUILDS		(X3) DATE 8 COMPL	SURVEY ETED
NAME OF	PROVIDER OR SUPPLIER	09G159	STOCET AN	1		04/1	3/2007
CAREC	•		6613 6TH	STREET, N STON, DC 2	STATE, ZIP CODE IW 20012		
(X4) ID PREFIX TAG	. I LEACH DEFICIENCY	YEMENT OF DEFICIENCIER MUST BE PRECEDED BY SCIDENTIFYING INFORMA	mit re (ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	III bee	COMPLETE DATE
l 1 39	This Statute is not	Met as evidenced by:		1135			
	pased on Staff inter	view and record reviewed and record May than				,	
	The finding includes						
	TOUCSSIONAL (OMRE	ualified Mental Retan) and review of the s t 3:11PM revealed the as follows:	1065-				·
	Weekdays/Weekend	ds	}	•	1135		
	1st Shift 7 AM to 3 F 2nd Shift 3 PM to 11 3rd Shift 11 PM to 7	PM = 3 PM to 11 PM	1		cross reference response for W440 of the federal deficient report.	ncy	
	Review of the fire dri to February 2007 rev to hold fire evacuatio (Third Shift)	/ealed that the facility	r fallari I				
1 161	3507.2 POLICIES AN	ND PROCEDURES		1 161		·	
	The manual shall be body of the GHMRP least annually.	approved by the governowed and shall be reviewed	erning d at		1161 The Policy and Procedures manual is reviewed and	-	
,	This Statute is not m Based on record review body failed to review annually.	ew the GHMRP now	eming edures		approved by the Director of Operations on an annual basis. Evidence of such review will be made availatin the manual.		
1	The finding includes:				5/11	/07	
nn i Legins	Review of the policy a tion Administration	ind procedure manua	al on				
TE FORM	1						

VDTB11

If continuation sheet 4 of 7

ND FLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROMDENSUPPLIE IDENTIFICATION NU	rvolia MBER:	(X2) MULT A. BUILDII B. WING		(X3) DATE S COMPL	SURVEY ETED
AME OF I	PROVIDER OR SUPPLIER	09G159		!`		04/	13/2007
					STATE, ZIP CODE		
CAREC	0 02		WASHING	STREET, N STON, DC 2	\W 20012		
(X4) ID PREFIX TAG	I (EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) OOMPL DATI
1161	Continued From pa	age 4		1 161		<u> </u>	
	April 11, 2007 at a	pproximately 1:10 PM hat the manual had be	i failed to een				
l 188	3508.6 ADMINISTI	RATIVE SUPPORT		1 188			
	as required by each Habilitation Plan incagreements, receip available for review	tion that services have been provided by each resident 's Individual Plan including contracts, vendor s, receipts, and paid bills shall be will be available by 5/31/07:		1/07:			
	This Statute is not	met as evidenced by			Pharmacist, Occupation Therapist. The facility used a sex therapist, the	has not	
	Based on record re	view, the GHMRP fail	led to		there is no active file for individual. If the need	r such an for the	
	The findings include	e ;			services of a sex therap the agency will provide	such with	,
	records/training rec following consultant Verify current contra	t 2:30 PM review of p ords revealed that the is records were unava- acts at the time of the pational Therapist, an	allable to		a qualified individual w all regulatory requireme	ho meets ents.	
1 206	3509.6 PERSONNE	EL POLICIES		1 206			
	annually thereafter, certification that a ho performed and that	or to employment and shall provide a physic ealth inventory has be the employee 's heal ter to perform the req	olan's en Ithetatus				:

VDT911

If continuation wheet 5 of 7

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUMBER 159		A BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPLI	ETED
NAME OF F	ROVIDER OR SUPPLIER	1	SYREET ADD	RESS CITY.	STATE, ZIP CODE	1 04/1	<u>3/2007</u>
CARECO	0 02		6613 6TH	STREET, N' TON, DC 2	W		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	אם מוווכ	(X5) COMPLET DATE
1 206	Based on record re have on file for revi for all employees. The finding include Review of the personal records.	met as evidenced by eview, the GHMRP failew current health cers: onnel files on April 13 to provide current health following:	led to tificates	1 206	1206 1a&b Health certificates we obtained for staff and medication nurse by 5/3 2a Health certificate for Registered Nurse will be obtained by 5/31/07. 2b. cross reference response 1188	31/07. ee	
I 379	each GHMRP shall Health, Health, Health Faci unusual incident or interferes with a resarrangement, well it places the resident be made by telephorollowed up by writt twenty-four (24) horomatical transfer is not Based on interview falled to ensure the	NCIES porting requirement in notify the Department in notify the Department in ities Division of any content which substantisted in the notification within the notification within the notification within the or the next work of the next work o	nt of other dially are, living vay shall shall be lay	1 379	·		

	gulation Administra	(X1) PROVIDER/SUPPLIES	R/CLIA MBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUR COMPLET	EO
AND PLAN OF	CORRECTION	DENTIL		B. WING		04/13	12001
Į	_	09G159	STORET ADD	RESS, CITY. 6	TATE, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER			CYCEET N	N		
			WASHING	TON, DC 20		ORRECTION	(XS)
(X4) ID PREFIX	SUMMARY S	FATEMENT OF DEFICIENCI CY MUST BE PRECEDED BY LISC IDENTIFYING INFORM	ES Y FULL (ATION)	(D PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TI DEFICIENCY	E APPROPRIATE	COMPLÉTE DATE
1379	Continued From substantially interest and welfare within work day. The findings income the aforement (24) hours or the aforement (24) hours or the Continue of a factor revealed the formula adaptive behavior support manager her acalled. 2. On 6/12/06 with oral anti-While being the determined the treatment (powas admitted)	page 6 Ifered with each resident twenty-four hours of twenty-four hours of twenty-four hours of twenty-four hours of twenty-four hours of the next day. O7, interview with the stion Professional (Qfillty unusual incident of the twenty-four hours as indicated on plan. Staff were the aggression and the position for a boil on hours of the area required ossible surgical debries.	dent's health or the next art of Health in twenty-for Qualified MRP) and report hibiting in her unable to olice was eing treated er right breat further dement) and	ast.	1379 1&2 The agency is policies on incident to ensure the fail-sof all regulatory by the appropriate times appropriate times. 3 Cross ref. W15 deficiency report	of management safe notification odies within ne allotted.	
	Todayara Administ	relien		6280	VDTB11		If continuation sheet 7